Patient Label

CASA House Referral

External referrals must be made by a health professional, such as a physician or therapist, and faxed to Alberta Health Services at 780-408-8776

Patient Information:

Legal First Name:	Legal Last Name:		
Preferred Name:			
Date of Birth: (dd-mmm-yyyy)	PHN:	Version Code:	Expiry Date:
Gender: ☐ Male ☐ Female ☐ Transgender ☐ Two Spirit ☐ Other			
Address:	City:	Postal Code:	
Is there a need for an interpreter? ☐ Yes ☐ No If yes, specify which language: _____	Are there any accessibility concerns? ☐ Yes ☐ No If yes, please specify: _____		

Fill out contact information for both parents/guardians with joint custody, or just one for sole custody. Please include custody or guardianship documents with this referral.

Caregiver / Guardian Information:

Name:		Name:	
Relationship:		Relationship:	
Address: (if different from above)		Address: (if different from above)	
City:	Postal Code:	City:	Postal Code:
Phone:		Phone:	
Email:		Email:	
Custody: ☐ Joint ☐ Sole ☐ Guardianship ☐ Other ☐ Other: (specify) _____		Custody: ☐ Joint ☐ Sole ☐ Guardianship ☐ Other ☐ Other: (specify) _____	

Referring Provider Information:

Physician Name:		PRAC ID:
Address:	City:	Postal Code:
Phone:	Fax:	
Email:	☐ Therapist ☐ Psychologist ☐ Psychiatrist ☐ Family Physician	

Does your patient currently have a psychiatrist? ☐ Yes ☐ No ☐ Unknown

If yes, name of psychiatrist: _____ Will this psychiatrist continue to provide care after discharge? ☐ Yes ☐ No

Does your patient currently have a mental health therapist? ☐ Yes ☐ No ☐ Unknown

If yes, name of therapist: _____ Will this therapist continue to provide care after discharge? ☐ Yes ☐ No

If the patient has a psychiatrist, it is preferred the referral comes from them. Alternatively, please attach consultation notes.

Primary Reason for the Referral: (specify current symptoms, presenting problems, and history).

Summary of Attached Documentation: (If any of the necessary documents are **NOT** submitted, the referral will be considered **INCOMPLETE**).

☐ The referral form.
☐ A mental health assessment.
☐ Psychological assessments and/or school reports.
☐ Discharge summary from previous mental health programs or hospital admissions.
☐ Any relevant supporting documentation.

Patient Engagement:

☐ Is the patient aware of the referral and interested in attending CASA House?
☐ Are the guardians in agreement and understanding of the program commitments?

Substance Use: (indicate current substances, amount, frequency, etc.)

Risk and Safety Concerns: (this information is used to optimally plan for the patient's first appointment, and to ensure their safety and the safety of our staff).

Risk Issue	Yes	No	If yes, when (dd-mmm-yyyy)	Details
Suicide attempt/ideation				
Deliberate self-harm				
Violent behavior/aggressive towards others				
Legal involvement				
Fire setting				
AWOL				

If any of the above risks and safety concerns are selected, you are REQUIRED to provide additional details.

Medication:

Medication Name	Current	Dose	Frequency	Response & Adverse Effects
	☐ Yes ☐ No			
	☐ Yes ☐ No			
	☐ Yes ☐ No			
	☐ Yes ☐ No			
	☐ Yes ☐ No			
	☐ Yes ☐ No			

School/Academics:

Working at grade level?	☐ Yes ☐ No
Learning disability?	☐ Yes ☐ No
Requires academic or behavior support in a school setting?	☐ Yes ☐ No
Psychoeducational testing or school report cards attached?	☐ Yes ☐ No

Agencies, Hospitals, or Therapy Involvement: (Within the past 2 years)**.**

Organization/Name of Provider	Describe Involvement

Relevant Medical/Developmental History: (i.e., disabilities, intellectual delay, autism, allergies, endocrine, neurological, respiratory, cardiac, prenatal exposure to drugs or alcohol, metabolic or other issues).

Completed by:

Name and Credentials: (print)	Date:
Signature:	

The information collected on this intake form is used to access the services of CASA Mental Health and is collected pursuant to section 22(2)(b) of the Health Information Act (HIA) in accordance with sections 20(b) and 21(1)(a) of the HIA. The Health Information Act and/or Personal Information Protection Act Protects the privacy of this information.